Application for Faculty License

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150 Ext. 222 Calls Taken 8:00am – 12:30pm, ET

All applicants for licensure in Kentucky are required to submit their background credentials to the Federation Credentials Verification Service (FCVS). FCVS is a service of the Federation of State Medical Boards and was created to help simplify the licensure process for physicians, both MD's and DO's. FCVS provides a permanent central depository for documents, which represent the core credentials of any physician. FCVS will conduct a primary source verification of those documents at the time they are submitted, and the physician will not be required to re-verify that information when applying to other state medical boards. **The FCVS application AND the Kentucky Board of Medical Licensure application are to be completed simultaneously but independently**. The FCVS and the Kentucky Board of Medical Licensure will forward notification of any materials needed by either organization to complete the application, separately to you.

FCVS Application Process

The primary source credentials of core documentation are verified in one uniform process created by FCVS and used in a lifetime portfolio for the applicant. **By using this service, the following core credentials are verified and kept in your lifetime portfolio for future credentialing by the FCVS:**

Identity
Medical Education Verification
Postgraduate Training Verification
Exam Scores
ECFMG and/or Fifth Pathway

You should **first** complete the FCVS application form and forward that directly to the FCVS along with their required fees. You should expect the FCVS verification process to take a minimum of eight weeks if this is your initial application with the FCVS. The address, telephone number and website are:

Federation Credentials Verification Service
PO Box 970900
Dallas, TX 75397-0900
(888) 275-3287
www.fsmb.org

The FCVS will provide all support of their credentialing process. **Do Not contact the Kentucky Board of Medical Licensure regarding the FCVS application.** The FCVS has a dedicated staff to ensure the processing of your application in a professional and timely manner. In addition, each applicant will be given a unique PIN number that will allow you to check the status of your application on-line. If you have previously completed the application process through FCVS, you will need to request a subsequent application packet.

Upon completion of all information and a final review for accuracy, the FCVS will forward your "Physician Information Profile" containing certified photocopies of your credentials directly to the Kentucky Board of Medical Licensure.

Next, you will need to complete the application for the Faculty License and submit this application directly to the Board along with the **$250.00 fee**. We highly recommend that you submit your application to the Board at the same time that you submit your FCVS application to the Federation of State Medical Boards.

Applications will be reviewed in the order they are received in our office. It takes approximately 60 – 90 days to complete the processing of an application, assuming you have submitted all necessary forms and all outside information/verifications have come in to the Board, including the FCVS Profile. If you have malpractice, disciplinary history, or we receive any negative or derogatory information during the processing of your application, ***you will need to allow an additional 30 – 60 days to complete***. **The Board does not accelerate processing of one applicant at the expense of another because of a premature commitment made on your behalf, nor will it forego any elements of its screening process. Please do not make firm commitments to start work on any certain date until you have your license in hand.**

Once your application has been reviewed, you will receive an acknowledgement letter advising you of anything still needed to complete your file. You should allow at least 30 days for this process. **Please do not contact the Board for the status of your application until such time.**

Applications must be printed legibly or they will be returned. Please complete all questions in its entirety. Do not leave any blanks or time not accounted for. Mark N/A in areas not applicable. Incomplete applications will remain in our office for one (1) year from the date your application is stamped received in our office. After one year, your file will be purged and you will have to start the application process over in its entirety including the fee. Also note that the **$250.00 licensure fee is non-refundable**.

We ask your cooperation in limiting your calls to the office to check on the status of your application. Please allow at least 30 days to receive notification of receipt and status (this could be delayed during peak months). When we use our limited staff resources on the phone, we are forced to delay processing of applications. All information regarding the status of a file will be in writing or may be obtained by calling **(502) 429-7150 Ext. 222 between 8:00 a.m. and 12:30 p.m., ET, Monday through Friday.** ***Please note that calls will only be taken during this timeframe.***

Verification of Primary Source documents

(Faxes Will Not Be Accepted)

Form 1 - **Verification of Licensure** - This form must be completed by each state/province/country in which you ***currently hold or have ever held*** any license to practice medicine/osteopathy (Include temporary and/or training licenses). This form must be sent ***directly*** to our office from each corresponding board and must contain the seal of the board. Any fees required for the completion of this form are your responsibility.

Form 2 - **Hospital/Clinic Affiliations -** Complete this form and return along with your application to the Board. List all hospital/clinic affiliations held for the past five (5) years. **List all places you have practiced medicine in the past 5 years.** ***Include all locum tenens assignments, moonlighting, and out of the country practice.***

Form 2A - **Hospital/Clinic Affiliation Form** - This form must be completed by all hospitals and/or clinics, locum tenens assignments, and/or moonlighting within the past 5 years. Include all places you have practiced medicine in the past 5 years. This form should be completed by administration or chairpersons. ***(Do not include your own private practice)***

Form 4 - **Release and Waiver of Rights Form** - Please read carefully. This form should be signed in front of a notary and returned along with your application.

Photograph – Attach **(do not staple)** a recent 2x2 **passport** photograph where indicated. Sign and date across the bottom. Photo must be no more than six months old and must be an original photograph. (Copies and scanned photos not accepted)

Form 7 - HIV/AIDS Education - Effective July 1, 1991, all applicants for medical licensure must comply with the two (2) hour HIV/AIDS education requirement mandated by the Kentucky General Assembly. A list of courses may be obtained from their web site at:
http://chfs.ky.gov/dph/training

Specialty Board Certification – Proof of Board Certification/Qualification must be sent directly from your certifying Board.

All Forms must be sent to the Board in the English language.

If you need duplicate forms above, they can be printed from our web site at www.kbml.ky.gov.

Application Deadlines and Board Meeting Dates

In order for your application to be presented to the Board, your application ***must be completed in its entirety and must be on file in the Board office by the deadline*** dates listed below **(There will be no exceptions to the deadlines).** The fact that you have mailed the application form and fee does not constitute a completed application. Your application is complete when the Board staff has reviewed all parts of the application including verification from all sources.

Deadline Dates	Board Meeting Dates
November 11, 2005	December 15, 2005
February 10, 2006	March 16, 2006
May 12, 2006	June 22, 2006
August 11, 2006	September 13, 2006
November 10, 2006	December 14, 2006

Faculty License Application Instructions

Please type or print clearly. Applicant must answer all questions. Indicate N/A where applicable. Incomplete applications will be returned. Faxes will not be accepted.

Completion of the Application Form

Item 1 – It is **important** to use your full legal name. Do not use nicknames, etc. This is the name that will be printed on the license and reported to all outside entities inquiring about licensure. List the degree designation as conferred by your medical/osteopathic school.

Item 2 & 3 – Provide the address of the school and department where you will be employed. All correspondence from the Board's office, including notice of renewals, will be mailed to the address provided.

Item 7 – List the name of the program and department where you have been accepted. Include a copy of the letter from the Dean of the school appointing you to this position,

Item 8 – List the school where medical/osteopathic degree was received.

Item 9 –List boards in which you are currently certified in your specialty.

Item 10 – List all internship and residency programs you have completed since medical or osteopathic school graduation. Use an additional sheet if necessary.

Item 11 – List all countries or jurisdictions where you currently hold or have ever held any type of medical/osteopathic licensure.

Item 12 – List any licensing examinations taken, including failures.

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Application for Faculty License

Licensure Telephone: (502) 429-7150, Ext. 222 between 8:00am-12:30 pm, EST

NOTE: Application must be legible and fully completed with all requested information and documentation supplied. Initial licensure fee of $250.00 must accompany application. This fee is non-refundable. ***09/14/05***

1. Name in Full

_____
(First) (Middle) (Last) (Degree)

2. Address

_____

3. City, State, Zip code

_____

4. Social Security Number _____ 5. Telephone: Home ( ) _____Work ( ) _____
6. Place of Birth _____ Date of Birth _____
7. List full-time faculty appointment at the medical or osteopathic school in Kentucky **(Must include a copy of the letter appointing you to this position)** _____
8. List name, location and dates of attendance of the school where medical/osteopathic degree was received:

Name	Location	Dates (From – To)	Degree

9. List boards in which you are certified in your specialty

_____

10. List all internship and residency programs you have completed since medical/osteopathic school graduation (**Please list in chronological order)**

INTERNSHIP:
Hospital: _____
City, Country: _____
Term: Started _____ Completed _____
RESIDENCY:
Hospital: _____
City, Country: _____
Term: Started _____ Completed _____
RESIDENCY:
Hospital: _____
City, Country: _____
Term: Started _____ Completed _____

11. List all countries or jurisdictions where you currently hold or have ever held any type of medical/osteopathic license

Country/Province	Type	License Number	Date of Issuance	Current Yes/No

12. Indicate which licensing examination(s) you have taken

Type (FLEX, NBME, USMLE, etc)	Location	Score	Date

13. Indicate your ECFMG number: _____

14. Are you able to understand, speak, read and write the English language? Yes _____ No _____

[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstance even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, or been placed on probation or reprimanded at a medical school or a post-graduate training program?
   ☐ Yes ☐ No

2. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐ Yes ☐ No

3. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☐No

4. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☐ No

5. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
   ☐Yes ☐ No

6. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐Yes ☐No

7. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
   ☐Yes ☐ No

8. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
   ☐Yes ☐No

9. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
   ☐Yes ☐No

10. Are any legal proceedings regarding licensure presently pending against you by any state, Federal or International licensure authority or any drug licensure/enforcement authority?
    ☐Yes ☐ No

11. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
    ☐Yes ☐No

12. To your knowledge, are you the subject of an investigation for a criminal act?

    ☐Yes ☐No

13. In the past ten (10) years have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against you or your medical practice presently pending in any court? If “Yes” attach explanation.
    ☐Yes ☐No

*****Affidavit of Applicant*****

I understand this license limits my practice to that required by this academic position and the limitation is so designated on the license in accordance with Board procedure and is also limited to the core teaching hospitals affiliated with the medical school, as identified by the Board, on which I am serving as a faculty member. This license shall remain in force for one year and may be renewed annually.

I further understand that this license does not preclude me from applying for a full and unrestricted license to practice medicine in Kentucky. I understand that to avoid a lapse in licensing, I should allow at least 2-3 months for the application process to be completed. I also understand that I must meet all licensure requirements set forth in KRS 311.571 to be eligible for a full and unrestricted Kentucky medical license. This includes, but is not limited to, successful completion of USMLE Steps 1, 2 and 3 and completion of 2 years of post-graduate training in the United States, Canada or other training approved by the Board. I also understand that I must complete an application package for a full and unrestricted medical/osteopathic license and supply all the documents required to support the application package.

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board or its agents to obtain form other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant) **(Date)**

_____

(Printed Name)

Subscribed and sworn to before me by the above named applicant this _____day of _____
(Month, Year)

_____

(Signature of Notary)

My commission expires:

_____

Seal of Notary

Attach current 2x2 passport photograph here. Sign and date across bottom. Photo must be a head and shoulder view and must be taken within six months of application.

[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them. "Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant) **(Date)**

_____

(Print Name)

Subscribed and sworn to before me by the above named applicant on this _____day of _____
(month, year)

_____

Seal of Notary **(Signature of Notary)**

My commission expires:_____

Medical Malpractice Form

Kentucky Board of Medical Licensure
310 Whittington Parkway Suite 1B
Louisville, KY 40222
(502) 429-7150

Complete this form only if you answered "yes" to Category I, Question #15. This form must be completed if you have been named as a defendant in a malpractice lawsuit, verdict or settlement in the past ten (10) years. Your application is not complete until this form has been returned to the Board.

_____

Name of Physician *Office Telephone No.*

_____

Address *City* *State* *Zipcode*

***Malpractice Complaint**: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)*

Patient's Name: _____

Age: _____ *Sex:* _____

Date/Place of Occurrence: _____

*Indicate your position in case, i.e., resident, primary physician,etc:*_____

Filed Against: *( ) Individual Doctor ( ) Group ( ) Hospital*

List names of other defendant-doctors and/or hospitals:

_____

_____

Disposition: *( ) Pending ( ) Jury Verdict ( ) Settled*

If there has been a verdict or settlement, please provide the following information:

*Legal Ooutcome:*_____

Date: _____ *Total Amount Paid (if any):* _____

*Amount attributable to you:*_____

You will need to send the Board, copies of the Complaint, Answer, Release, Settlement Documents, and All Other Relevant Legal Documents.

On A Separate Sheet, Please Provide A Detailed Explanation Of Background And Medical Issues Involved In The Case.

Signature: _____ *Date:* _____

→ A separate report must be completed for <u>each</u> malpractice suit. This form may be duplicated. Please return form(s) and other information to the Board at the above address.

Form 1

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Verification of Licensure

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires **each** state, country, or other jurisdiction where you **currently hold or have ever held** a medical license complete this form. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name of Applicant: _____M.D./D.O. License No:_____
(Please print)

Address:_____

_____M.D./D.O.
(Signature)

****

To Reference Source: Please complete this form, sign, seal and return directly to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the physician. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

• • • Please Type or Print All Information • • •

State or Country of:_____ License No:_____

Issue Date:_____ Expiration Date:_____

Basis for Licensure:_____

Current Status:_____

Limitations: _____

Derogatory:_____

_____

Signed: _____

Board Seal

Title: _____

Form 2

Physicians Name _____M.D. / D.O.

List all hospitals, clinics, etc., other than training where you have practiced medicine within the last five (5) years and send Form 2A to each. *(This should also include moonlighting, administrative, and all locum tenens assignments.) This form also includes out of country facilities.*

Dates (From – To)	Hospital/Clinic/Office Name	Complete Address	Indicate Locum Tenens, Moonlighting or Type of Privileges

Form 2A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name:_____M.D./D.O. _____
(Please print) (Signature)

Name and Address of Facility:_____

****

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. Position and Department of the above applicant?_____
2. Affiliation Dates: From _____To _____
3. Were any limitations imposed on this physician?_____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action._____
   _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
   _____
   _____
5. Was the above physician terminated from employment? ___ If yes, please explain in detail.

   Derogatory Information, if any:_____

   Comments, if any:_____

Signature, Date, Title _____

Printed Name _____

Facility _____

Affix Seal Here

Address _____

(If no seal, so indicate)

_____

Phone Number _____

Form 4

Release and Waiver of Rights Form

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools that I have attended.

2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

3. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have been associated.

4. All other state, country or other licensure boards, Jurisdictions, federal health agencies, and federal and state/country drug control agencies.

5. All licensed physicians, nurses or other health care professionals of any state, country, Canadian province or other jurisdiction.

6. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements for licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, country, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that ease of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

_____

(Applicant's Signature) (Date)

_____

(Print Name)

Sworn to and Subscribed Before Me By the Above Named Applicant on this the __day of _____, 20____

Seal

_____

Notary Public

My Commission expires:_____

Form 7

Kentucky Board of Medical Licensure
HIV/AIDS Education Certificate Requirements

During the 1990 regular legislative session, the General Assembly passed House Bill 425, which mandated Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) education requirements for health professionals. Further, the General Assembly mandated that the Cabinet for Health Services (CHS) administers this program and that the Kentucky Board of Medical Licensure monitor compliance.

On or after September 24, 1991, all applicants for medical licensure must comply with the two (2) hour AIDS education requirement.

Prior to receiving a Kentucky medical license, each applicant for licensure must submit to the Kentucky Board of Medical Licensure one of the following:

- A copy of a certificate of completion of an approved course. The AIDS course (2 hours minimum) must be included on the official listing of approved courses maintained by the Cabinet for Health Services, and the CHS approval number must appear on the certificate. **Certificates without a CHS approval number will not be accepted.**

- An "Affidavit of Reasonable Cause" form if the requirement is not met prior to temporary licensure. If the AIDS course is not completed by the time a temporary license is to be issued, the applicant must complete an "Affidavit of Reasonable Cause" form to verify that the requirement will be met within the next six (6) months. This affidavit shall be valid for no more than six (6) months and is not renewable. Eligible applicants will be issued a Temporary Permit only for this six (6) month period. The full license to practice medicine in Kentucky will not be issued until this requirement is met.

- If an applicant has graduated from a medical/osteopathic school, whose AIDS education is approved by CHS, within five (5) years and has been in a residency program throughout the interim, the applicant shall be deemed to have met this requirement. **Contact the AIDS Education Program at CHS to see if your medical school curriculum has been approved**. (See below)

If you have any questions regarding applicable courses, approval of courses, or if you need **to obtain a listing of approved courses,** please contact:

http://chfs.ky.gov/dph/training

AIDS Education Program
Cabinet for Health Services
275 East Main Street
Frankfort, KY 40621
(502) 564-4990